SUPPORTING STATEMENT FOR THE INFORMATION COLLECTION REQUIREMENTS CONTAINED IN THE EXEMPTIONS ELIGIBILITY INFORMATION COLLECTION REQUEST

A. Background

The Patient Protection and Affordable Care Act, Public Law 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, enacted on March 30, 2010 (collectively, "Affordable Care Act"), expand access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Insurance Exchanges (Exchanges), including the Small Business Health Options Program (SHOP). The Exchanges, which will become operational by January 1, 2014, will enhance competition in the health insurance market, expand access to affordable health insurance for millions of Americans, and provide consumers with a place to easily compare and shop for health insurance coverage.

The data collection and reporting requirements in "Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions" (CMS-9958-F, 78 FR 39518), address federal requirements that states must meet with regard to the Exchange minimum function of performing eligibility determinations and issuing certificates of exemption from the shared responsibility payment. In the final regulation, CMS addresses standards related to eligibility, including the verification and eligibility determination process, eligibility redeterminations, options for states to rely on HHS to make eligibility determinations for certificates of exemption, and reporting.

We have included seven appendices of application materials to illustrate the process applicants will use to apply for exemptions from the shared responsibility payment.

- Appendix A- Religious Conscience: This application is for applicants who wish to be exempt from the shared responsibility payment if the applicant is a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare.
- Appendix B- Health Care Sharing Ministry: This application is for applicants who wish to be exempt from the shared responsibility payment if the applicant is a member of a recognized health care sharing ministry.
- Appendix C- Incarceration: This application is for applicants who wish to be exempt from the shared responsibility payment if the applicant is incarcerated, and not awaiting the disposition of charges against you.
- Appendix D-American Indian/Alaskan Native: This application is for applicants who wish to be exempt from the shared responsibility payment if the applicant is a member of a federally recognized tribe or eligible for services through an Indian health care provider.
- Appendix E-Hardship: This paper application is for applicants who wish to be exempt from the shared responsibility payment based on one of the following circumstances:
    1. You were homeless.
    2. You were evicted in the past 6 months or were facing eviction or foreclosure.
    3. You received a shut-off notice from a utility company.
    4. You recently experienced domestic violence.
    5. You recently experienced the death of a close family member.

6. You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.
7. You filed for bankruptcy in the last 6 months.
8. You had medical expenses you couldn't pay in the last 24 months.
9. You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.
10. You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, you do not have the pay the penalty for the child.
11. As a result of an eligibility appeals decision, you're eligible for enrollment in a qualified health plan (QHP) through the Exchange, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Exchange.
12. You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.

- Appendix F- Lack of Affordable Coverage Based on Projected Income (Federally-facilitated Marketplace): This paper application is for applicants who wish to be exempt from the shared responsibility payment based on a lack of affordable coverage calculated using projected annual household income.

- Appendix G- Lack of Affordable Coverage Based on Projected Income (Certain State-based Marketplaces): This paper application is for applicants in certain states where there is a State-based Marketplace who wish to be exempt from the Shared Responsibility payment based on a lack of affordable coverage calculated using projected annual household income.

The submission seeks OMB approval of the information collection requirements associated with 45 CFR parts 155.

B. Justification

1. Need and Legal Basis

Section 1501(b) of the Affordable Care Act added section 5000A of the Internal Revenue Code (the Code) to a new chapter 48 of subtitle D (Miscellaneous Excise Taxes) of the Code effective for months beginning after December 31, 2013. Section 5000A of the Code, which was subsequently amended by the TRICARE Affirmation Act of 2010, Public Law 111-159 (124 Stat. 1123) and Public Law 111-173 (124 Stat. 1215), requires that nonexempt individuals either maintain minimum essential coverage or make a shared responsibility payment, includes standards for the calculation of the shared responsibility payment, describes categories of individuals who may qualify for an exemption from the shared responsibility payment, and provides the definition of minimum essential coverage.

Section 1311(d)(4)(H) of the Affordable Care Act specifies that the Exchange will, subject to section 1411 of the Affordable Care Act, grant certifications of exemption from the shared responsibility payment specified in section 5000A of the Code. Section 1311(d)(4)(I)(i) of the Affordable Care Act specifies that the Exchange will transfer to the Secretary of the Treasury a list of the

individuals to whom the Exchange provided such a certification. Section 1411(a)(4) of the Affordable Care Act provides that the Secretary of Health and Human Services (the Secretary) will establish a program for determining whether a certification of exemption from the shared responsibility requirement and penalty will be issued by an Exchange under section 1311(d)(4)(H). We interpret this provision as authorizing the Secretary to determine "whether," with respect to the nine exemptions provided for under section 5000A, Exchanges would perform the role of issuing certifications of exemption under section 1311(d)(4)(H), whether eligibility for the exemption would be determined solely through tax filing, or whether both processes would be available. Under this interpretation, the responsibility under section 1311(d)(4)(H) to issue certifications of exemption would be "subject to" these determinations by the Secretary under section 1411(a)(4), and Exchanges would thus only be required to issue certifications of exemption with respect to exemptions not exclusively assigned to IRS.

Section 1321 of the Affordable Care Act discusses state flexibility in the operation and enforcement of Exchanges and related requirements. Section 1321(a) provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges and other components of title I of the Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under Subtitle D of Title I of the Affordable Care Act.

In accordance with our interpretation of these sections of the Affordable Care Act, and the authority provided by, *inter alia*, section 1321(a) of the Affordable Care Act, we specify that under the program established under section 1411(a)(4) of the Affordable

Care Act, the Exchange would determine eligibility for and grant certificates of exemption as described below.

These information collection requirements are set forth in 45 CFR Parts 155.

2. Information Users

The data collection and reporting requirements described below are critical to the basic ability of Exchanges to determine eligibility for and issue certificates of exemption, and will also assist Exchanges, HHS, and IRS in ensuring program integrity and quality improvement.

3. Use of Information Technology

HHS anticipates that a majority of the activities described below in this rule will be automated. Exchanges are expected to develop automated notice templates for many of the specified notices, and distribute the majority of these notices through secure electronic accounts. The entities issuing notices or collecting information will develop the initial template after which the templates will be automatically populated with the appropriate information for the receiving party. A majority of the information that is collected in accordance with this rule will be submitted electronically. Staff, or systems, will analyze, review, or process the data through largely electronic means and communicate with individuals, states, and HHS using e-mail, telephone, or other electronic means whenever possible.

4. Duplication of Efforts

These information collections do not duplicate any current information collections. They contain information needed for a new program.

5. Small Businesses

We estimate minimal burden on small business as they are not required to issue certificates of exemption.

6. Less Frequent Collection

Due to the required flow of information between multiple parties, it is necessary to collect information according to the indicated frequencies. If the information is collected less frequently, the result would be less accurate, untimely or unavailable information about eligibility determinations for Exchanges, HHS, IRS, and individuals. This would have implications on the federal tax filing process due to IRS's reliance on information about eligibility determinations and certificates of exemption that have been issued by the Exchange in order for IRS to administer the shared responsibility payment. As it specifically relates to the exemption application, if information was collected less frequently or not at all, individuals would not be able to obtain a certificate of exemption and the program would be unable to operate. In summary, if the information is collected less frequently, it would lead to an overall stress on the organizational structure of the Exchanges and decrease in benefit to individuals.

7. Special Circumstances that may cause respondents to submit information in fewer than 30 days

In §155.620(b), we provide that with the exception of §155.620(b)(2), an individual who has a certificate of exemption from the Exchange must report any change with respect to the eligibility standards for the exemption as specified in §155.605, with the exception of § 155.605(g)(2), within 30 days of such change. The Exchange will conduct a redetermination of eligibility for the exemption based on the reported change.

8. Federal Register/Outside Consultation

As part of Exchange implementation to date, we have consulted with contractors, academia, states, and industry of the feasibility of this information collection. CMS has sought input from states and other federal agencies, such as IRS. We have based several of the requirements in this information collection from the consultations with these outside entities.

9. Payments/Gifts to Respondents

No payments and/or gifts will be provided to respondents.

10. Confidentiality

To the extent of the applicable law and HHS policies, we will maintain respondent privacy with respect to the information collected.

11. Sensitive Questions

As it relates to the exemption application, a social security number will be collected for purposes of verifying incarceration status, citizenship, and household income and family size depending on the exemption category, as well as for purposes of tax administration.

12. Burden Estimates (Hours & Wages)

For purposes of presenting an estimate of paperwork burden, we recognize that not all states will elect to operate their own Exchanges and that territories may participate in operating an Exchange, and thus have provided greater specificity related to the number of conditionally approved state-based Exchange where relevant. We also note that these estimates generally reflect burden for the first year, and that the associated burden in subsequent years will be significantly lower because many of the standards in the

regulation will be fulfilled through the development of automated processes that will involve only maintenance in future years. Therefore, these estimates should be considered an upper bound of burden for non-federal entities. These estimates may be adjusted in future PRA packages as Exchange development moves forward.

We utilize data from the Bureau of Labor Statistics to derive average costs for all estimates of salary in establishing the information collection requirements. Salary estimates include the cost of fringe benefits, calculated at 30.4 percent of total labor costs, which is based on the June 2012 Employer Costs for Employee Compensation report by the U.S. Bureau of Labor Statistics. Additionally, we utilize estimates from the Congressional Budget Office for estimates related to the number of exemption applications we anticipate receiving, and the number of exemption eligibility determination notifications we anticipate Exchanges to generate.

It is important to note that these regulations involve several information collections that will occur through the application for exemptions, as described in §155.610(a), and the notification of eligibility determination, as described in §155.610(i). We have accounted for the burden associated with these collections in this information collection requirement. We include data elements associated with the application and relevant notice requirements in Appendices A and B.

PART 155- EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

Subpart G— Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions

A. Eligibility process for exemptions (§155.610)

Throughout the subpart G, we specify that the Exchange collect

attestations from applicants for a certificate of exemption. These attestations will be collected using the application described in §155.610(a). In §155.610(a), we provide that the Exchange use an application created by HHS to determine eligibility for and to collect information necessary for issuing certificates of exemption. §155.610(b) allows the Exchange to use an alternative application to collect the information necessary for issuing certificates of exemption. However, the alternative application must be HHS approved and it must collect the minimum information necessary for determining eligibility for and issuing certificates of exemption. The burden associated with this requirement is the time and effort associated with an applicant completing an application.

While the Congressional Budget Office[1] estimates that 24 million individuals would be exempt from the individual shared responsibility payment in 2016, it is unclear how many individuals will seek these exemptions from an Exchange. Some of these individuals will claim an exemption through the tax filing process, others will be exempt but not need to file for an exemption (for example those below the filing threshold), while others will apply for and receive an exemption through the Exchange. Therefore, of the 24 million individuals, we conservatively anticipate that up to half will apply for an exemption through the Exchange. We specifically sought comment on this assumption.

The exemption application may be available in both paper and electronic formats. The electronic application process will vary depending on each applicant's circumstances and which exemption an applicant is applying, such that an applicant is only presented with questions relevant to the exemption for which he or she is applying. The goal is to solicit sufficient information so that in most cases no further inquiry will be needed. We estimate that on average the application will take approximately .27 hours (16 minutes)

[1] Congressional Budget Office, "Payments of Penalties for Being Uninsured Under the Affordable Care Act," September 2012, http://cbo.gov/sites/default/files/cbofiles/attachments/09-19-12-Indiv_Mandate_Penalty.pdf

for an application filer to complete an application, which is based on the estimates created for the single, streamlined application for enrollment in a QHP[2], with a 90 percent electronic / 10 percent paper mix (noting that no specific application channel is specified in this final rule). We conservatively anticipate up to 12 million applications for exemptions will be submitted to the Exchange, for a total of approximately 3.2 million burden hours. We note, however, that the Commonwealth of Massachusetts saw a very small number of individuals apply for exemptions from a similar individual shared responsibility payment[3].

We also note that some individuals will apply for an exemption but be determined ineligible for an exemption, but it is difficult for us to estimate this number, and that in an unknown number of cases, multiple individuals in a single household may submit a single application.

Table 1 - Estimated Annualized Burden for Exemptions Application

Labor Category	**Number of Respondents**	**Number of Responses Per Respondent**	**Average Burden Hours per Response**	**Total Burden Hours**
Individual	12 million	1	0.27	3,200,000
Total	12 million			3,200,000

[2] The estimates may be found in the information collection request entitled, "Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children's Health Insurance Program Agencies (CMS-10440/OCN-0938-1191)."

[3] Massachusetts Health Connector and Department of Revenue, "Data on the Individual Mandate, Tax Year 2010", June, 2012. Retrieved from http://www.mahealthconnector.org

We estimate that the cost to develop the exemption application will be significantly less than the estimated cost of developing the coverage application because the coverage application takes into account additional factors necessary in order to perform eligibility determinations for insurance affordability programs. In total, we estimate that this will take a developer approximately 1,059 hours to develop the exemption application at an average labor cost of $98.50 per hour, for a total cost of $104,312 per Exchange and a total cost of $1,877,607 for 18 state-based Exchanges. While we have estimated this on a per-Exchange basis, we note that HHS will be releasing a model application, which should significantly decrease the burden for any state that uses it.

Table 2 – Estimated Burden for Development of Exemptions Application

Labor Category	Number of Employees	Hourly Labor Costs	Burden Hours	Burden Costs (per Exchange)	Total Burden Costs (18Exchanges)
Application Development	1	$98.50	1,059	$104,312	$1,877,607

Section 155.610(f) specifies that the Exchange determine an applicant's eligibility for an exemption and issue a certificate of exemption to any applicant deemed eligible. §155.610(i) provides that the Exchange notify exemption applicants of any eligibility determination made as a result of the application. If an individual is eligible for an exemption, the notification provided to the applicant will satisfy the requirement that the Exchange provide a certificate of exemption, provided that all relevant noticing standards for exemptions are met. Accordingly, we do not provide a separate burden estimate for the standard described under §155.610(f) because the burden estimate for §155.610(i) encompasses the burden for both requirements.

The notification of eligibility determination, or certificate of exemption, provides information to an applicant about his or her eligibility for an exemption, including information about the time frame for which the exemption is effective, and appeal rights. When possible, we anticipate that the Exchange will consolidate this notice when multiple members of a household are applying for an exemption together and receive an eligibility determination at approximately the same time. Consistent with 45 CFR 155.230(d), the notice may be in paper or electronic format, based on the election of an individual, will be in writing, and will be sent after an eligibility determination has been made by the Exchange; these are the same standards that are used for eligibility notices for enrollment in a QHP through the Exchange and for insurance affordability programs, as described in 45 CFR 155.310(g). It is difficult to estimate the number of applicants that will opt for electronic versus paper notices, although we anticipate that a large volume of enrollees will request electronic notification while others will opt to receive the notice by mail. We estimated the associated mailing costs for the time and effort needed to mail notices in bulk to applicants who request paper notices.

We expect that the exemption eligibility determination notice will be dynamic and include information tailored to all possible outcomes of an application. To develop the notice, Exchange staff would need to learn exemption eligibility rules related to exemptions and draft notice text for various decision points, follow up, referrals, and appeals procedures. A health policy analyst, senior manager, and an attorney would review the notice. The Exchange would then engage in review and editing to incorporate changes from the consultation and user testing including review to ensure compliance with plain writing, language access, and readability standards. Finally, a computer programmer would program the template notice into the eligibility system so that the notice may be populated and generated in the correct format.

HHS is currently developing model notices, which will decrease the burden on Exchanges associated with providing such notices. If a state opts to use the model notices provided by HHS, we estimate that the Exchange effort related to the development and implementation of the exemption eligibility determination notice will necessitate 44 hours from a health policy analyst (occupation no. 13-2031) at an hourly cost of $49.35 to learn exemptions rules and draft notice text; 20 hours from an attorney (occupation no. 23-1011) at an hourly cost of $90.14, and four hours from a senior manager (occupation no. 11-1021) at an hourly cost of $79.08 to review the notice; and 32 hours from a computer programmer (occupation no. 15-1131) at an hourly cost of $52.50 to conduct the necessary development. In total, we estimate that this will take a total of 100 hours for each Exchange, at a cost of approximately $5,971 per Exchange and a total cost of $107,469 for 18 state-based Exchanges. We expect that the burden on the Exchange to maintain this notice will be significantly lower than to develop it. We estimate that it will take each professional approximately a quarter of the time to maintain the notice as compared to developing the notice. Accordingly, we estimate the maintenance of the eligibility determination notice in subsequent years will necessitate 11 hours from a health policy analyst at an hourly cost of $49.35; 5 hours from an attorney at an hourly cost of $90.14; one hour from a senior manager at an hourly cost of $79.08 and eight hours from a computer programmer at an hourly cost of $52.50. In total, we estimate that this will take a total of 25 hours for each Exchange, at a cost of approximately $1,492 per Exchange and a total cost of $26,856 for 18 state-based Exchanges.

Table 3- Estimated Burden for Development and Maintenance of Exemption Eligibility Notice

Labor Category	Number of Employees	Hourly Labor	Burden Hours	Total Burden Costs (per	Total Burden Costs (18

		Costs		Exchange)	Exchanges)
Health Policy Analyst	2	$49.35	55	$2,171	
Attorney	1	$90.14	25	$1,802.87	
Senior Manager	1	$79.08	5	$316.32	
Computer Programmer	1	$52.50	40	$1,680	
Total			125	$7,463	$26,856

We also include an estimate for the total printing and mailing costs related to sending eligibility determination notices for all 50 states and the District of Columbia. This includes the cost of a mail clerk (occupation no. 43-9051) spending two hours to coordinate the mailing of paper notices as necessary. As noted previously, we estimated 12 million total applications for 2016. While each of these applications will receive an eligibility determination notice, we estimate that approximately 1.2 million notices will need to be printed and mailed, while the remainder will be sent electronically (based on the user's preferences). We note that it is difficult to estimate how many individuals will elect to receive electronic versus paper notices. We use these assumptions to determine the number of eligibility notices that we expect to be printed and distributed as described in §155.610(i).

Table 4- Estimated Mailing Costs for Eligibility Determination Notices

	Number of Notices	Printing/Mailing Costs per notice	Total Burden Cost (all Exchanges)
Printing/Mailing	1.2 million	$.50	$600,000

Pursuant to section 5000A of the Code, the IRS must collect the necessary data from QHP issuers to determine the national average bronze monthly premiums in order to assist in the computation of the shared responsibility payment. To assist the IRS, HHS must request the monthly premium for all bronze level QHP's through all 51 Exchanges from QHP issuers. The burden associated on states and QHP issuers is already included in the information collection request entitled, "Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations," and as such, we do not include a separate burden estimate here. As this information is already being collected for another purpose, there will be no additional burden on QHP issuers or states.

B. Verification process related to eligibility for exemptions (§155.615)

§155.615 outlines the standards for Exchanges to verify applicant information as it pertains to exemption requests.

In §155.615(g), we outline the process for resolving inconsistencies identified through the verification process. We anticipate that the Exchange eligibility system will be able to process most applications in an automated fashion and that only the more complex cases will necessitate the resolution of inconsistencies or adjudication of documentation through an offline process. For example, the Affordable Care Act designates authority to the Secretary of HHS to establish the criteria by which an individual will qualify for a hardship exemption, and we believe that for in several cases, individuals may have to submit documentation to the Exchange to substantiate the hardship he or she experienced. Given the fact that the Exchange eligibility process for exemptions is entirely new and involves the use of new electronic data sources in combination with a new application, it is not possible at this time to provide estimates for the number of applicants for whom additional information will be required to complete an eligibility determination, but

we anticipate that this number will decrease as applicants become more familiar with the eligibility process for exemptions and as more data become available electronically.

In §155.615(g)(2)(i), we specify that the Exchange will provide notice to an applicant regarding any inconsistencies identified through the verification process. This notice of inconsistency is a part of the notice in §155.610(i), and so we do not include a separate burden estimate here.

Section §155.615(g)(2)(ii) provides that in the case of an inconsistency that cannot be resolved through the action taken by the Exchange under §155.615(g)(1), the Exchange must request that the individual provide satisfactory documentation or otherwise resolve the inconsistency. Our estimates below reflect the time and effort required for an individual to collect information and provide it to the Exchange, as well as time needed for eligibility support staff (occupation no. 43-4061) to review the documentation, since we are unable to estimate the number of individuals who will receive such a notice. We expect that it will take an individual one hour to gather the relevant documentation, five minutes to upload or mail the relevant documentation, and 12 minutes for eligibility support staff to review the documentation, which reflects our expectation that each individual who is required to submit documentation will submit 2.2 documents for review. We estimate that it will take an individual one hour to collect and submit the relevant documentation, and 12 minutes for eligibility support staff at an hourly cost of $28.66 to review the documentation, for a total cost of $6 per document submission.

Table 5- Estimated Burden for Inconsistencies

	Number of Individuals /Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per individual)
Individual	1	--	1	--
Eligibility Support Staff	1	$28.66	.20	$6
Total	2		1.2	$6

Section 155.615(g)(4) provides that if after that the period described in paragraph (g)(2)(ii) of this section, the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility for an exemption based on any information available from the data sources used in accordance with this subpart, if applicable, unless such applicant qualified for the exception for special circumstances under paragraph (g)(3) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in §155.610(f) and §155.610(i), including notice that the Exchange is unable to verify the attestation. We do not include a separate burden estimate for this notice because the burden for this notice is described under §155.610(i).

C. Eligibility redeterminations for exemptions during a calendar year (§155.620)

Section 155.620(b)(1) specifies that the Exchange require an individual who has a certificate of exemption from the Exchange to report any change with respect to the eligibility standards for the exemption within 30 days of such change. Upon receipt of changes reported by an individual, §155.620(c)(1) provides the Exchange will verify the information in accordance with the rules described in §155.615. Our estimates reflect the time that it would take for an individual to collect information related to a change that impacts their eligibility, as well as the time it would take to report these changes to the Exchange. We expect that a large volume of changes

would be reported electronically by enrollees. We expect that it will take an enrollee approximately ten minutes to report a change to the Exchange.

Table 6- Estimated Burden for Reporting Changes

	Number of Individuals	Hourly Labor Costs	Burden Hours	Total Burden Costs (per change)
Individual	1	--	.16	--
Total			.16	--

The Exchange will use the same verification processes for new applications and for changes that are reported during the year. In §155.620(c)(1), we provide that the Exchange will verify any information reported by an enrollee in accordance with the processes specified in §155.615 prior to using such information in an eligibility redetermination. It is not possible at this time to provide estimates for the number of applicants for whom additional information will be required to complete an eligibility determination, but we anticipate that this number will decrease as applicants become more familiar with the eligibility process and as more data become available. As such, for now, we note that the burden is one hour for an individual to collect and submit documentation, and 12 minutes for eligibility support staff at an hourly cost of $28.66 to review the documentation, for a total cost of $6 per document submission. We solicit comment on the number of applicants for whom a change report with necessitate the adjudication of documentation.

Table 7- Estimated Burden for Verifying Information

	Number of Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per inconsistency)
Individual	1	--	1	--
Eligibility Support Staff	1	$28.66	.2	$6
Total	1		1.2	$6

In §155.620(c)(2), we specify that the Exchange will provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes as described in paragraph (b)(3) of this section, to an individual who has elected to receive electronic notifications, unless he or she has declined to receive notifications under this paragraph. For each Exchange, we expect that this will take 21 hours total, 20 hours for an operations analyst to integrate this electronic notification into the Exchange eligibility system, and one hour for a computer programmer to program the electronic notifications into the eligibility system. We estimate a cost burden of $1,040 per Exchange and a total cost of $18,720for 18 state-based Exchanges.

Table 8- Estimated Burden for Periodic Electronic Notifications

Labor Category	Number of Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per Exchange)	Total Burden Costs (18 Exchanges)
Health Policy Analyst	1	$49.35	20	$987	
Computer	1	$52.50	1	$52	

Programmer					
Total	2		21	$1,040	$18,720

In §155.620, we describe the redetermination and notification procedures when an individual reports a change to the Exchange. As described above, 155.620(a) provides that if the Exchange verifies updated information reported by an enrollee, the Exchange must redetermine the enrollee's eligibility in accordance with the standards specified in §155.605. Section 155.620(c)(2) specifies that the Exchange notify the individual regarding the redetermination in accordance with the requirements specified in §155.610(f) and §155.610(i). The burden for this notice is identical to the burden associated with the eligibility notice described in §155.610(i).

D. Options for conducting eligibility determinations (§155.625)

Section §155.625 of the regulation provides options for conducting eligibility determinations. These provisions specify that an Exchange that decides to utilize the HHS service for making eligibility determinations for exemptions for application submitted on or after October 15, 2014, will enter into a written agreement with HHS. These agreements are necessary to ensure that the use of the service will minimize burden on individuals, ensure prompt determinations of eligibility without undue delay, and provide for secure, timely transfers of application information.

The burden associated with these provisions is the time and effort necessary for the Exchange to establish an agreement with HHS. We estimate that the creation of the necessary agreement will necessitate 35 hours from a health policy analyst at an hourly cost of $49.35, and 35 hours from an operations analyst at an hourly cost of $54.45 to develop the agreement; and 30 hours from an attorney at an hourly cost of $90.14 and five hours from a senior manager at an hourly cost of $79.14 to review the agreement. For the

purpose of this estimate, we assume that the 18 state-based Exchanges will utilize the HHS service for exemptions. Accordingly, the total burden on the Exchange associated with the creation of the necessary agreement will be approximately 105 hours and $6,733 per Exchange, for a total cost of $121,194 for 18 Exchanges.

Table 9- Estimated Burden for Agreements

Labor Category	Number of Employees	Hourly Labor Costs	Burden Hours	Total Burden Costs (per Exchange)	Total Burden Costs (per year)	
Health Policy Analyst	1	$49.35	35	$1,727	$31,086	
Operations Analyst	1	$54.45	35	$1,906	$34,308	
Attorney	1	$90.14	30	$2,704	$48,672	
Senior Manager	1	$79.08	5	$395	$7,110	
Total			105	$6,733	$121, 194	

E. Reporting (§155.630)

In §155.630, we specify that when the Exchange issues certificates of exemption to

individuals in accordance with the requirement contained in §155.610(i), the Exchange promptly transmit to IRS the individual's names, Social Security numbers, and any other information required in guidance published by the Secretary of the Treasury in accordance with 26 CFR 601.601(d)(2). As these reporting functions will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system.

13. Capital Costs

We anticipate that the majority of capital costs associated with these information collections, as well as the burden and costs associated with the transactions described in §155.615 related to verification, will be related to the implementing regulations found in Subparts D and E that provide for a streamlined eligibility and enrollment system. We anticipate that States that have elected to operate an Exchange will perform eligibility determinations and issuing certificates of exemptions by using the information technology system that the State has already built or modified in order to meet the other minimum functions of an Exchange related to eligibility and enrollment under subparts D and E of the Exchange final rule. Any administrative costs incurred in the development of information technology infrastructure to support the Exchange may be funded wholly through State Exchange Planning and Establishment Grants. The Federal government expects that these grants will fund the development of IT systems that can be used by many States who either develop their own Exchanges or who partner with the Federal government to provide a subset of Exchange services.

Table 10 includes estimates of grants from 2013 to 2017. It does not include costs related to reduced Federal revenues from refundable premium tax credits, which are administered by the Department of the Treasury and subject to IRS rulemaking. It does not

include the Medicaid effects, or the policies whose offsets led CBO to estimate that the Affordable Care Act would reduce the Federal budget deficit by over $100 billion over the next 10 years. Table 1 also includes the estimates for outlays for grants to States for Exchange start up.

Table 10. Estimated Outlays for the Affordable Insurance Exchanges FY 2013 - FY2017, in billions of dollars

Year	**2013**	**2014**	**2015**	**2016**	**2017**	**2013-2017**
Grant Authority for Exchange Start up[b]	1.5	2.1	1.7	0.8	0.2	6.2

[b] FY 2014 President's Budget

Other administrative costs to support the streamlined and coordinated eligibility and enrollment process and the associated information collections will also vary for each State depending on the specific approaches taken, including how the state chooses to support the review of paper documentation and the resolution of eligibility and enrollment issues, or whether the state chooses to utilize the federally managed service for issuing exemptions. We also believe that overall administrative costs may increase in the short term as States build information technology systems; however, in the long-term States will see savings through the use of more efficient systems and consolidation across programs.

14. Cost to Federal Government

We anticipate that the costs to the Federal government include costs related to 1) implementation of the federally-facilitated Exchange and the associated requirement to issue exemptions, and 2) providing the federally managed service for exemptions. As the FFE, costs related to implementation would be the same as the costs described in the burden estimates for each Exchange above and

would vary depending on the number of states that opt to participate as an FFE. Costs related to providing the federally-managed service for exemptions relate primarily to the number of state-based Exchanges that decide to utilize the federally managed service for exemptions. Additionally, costs related to the federally-managed service would be similar to the costs described in the burden estimates for each Exchange above, with the exception that it would not include burden related to the application and notification of eligibility determination, since we specify that the state-based Exchange handle the responsibilities of accepting the application and generating the notice if it is utilizing the service for applications submitted after October 15, 2014.

Accordingly, we note that HHS will be responsible for developing an exemptions application and exemptions notices that will be utilized across all FFEs. As such, we estimate that it will take the federal government a total of 1,059 hours to develop the application, at a cost of $104,312. We also estimate that it will take the federal government 125 hours to develop exemptions notices, at a cost of $7,463.

15. Changes to Burden

This is a new data collection.

16. Publication/Tabulation Dates

Not applicable

17. Expiration Date

Not applicable

Health Insurance Marketplace

Form Approved
OMB No. 0938-XXXX

Application for Exemption from the Shared Responsibility Payment for Members of Recognized Religious Sects or Divisions

THINGS TO KNOW

Use this application to apply for an exemption from the shared responsibility payment

- Starting in 2014, every person needs to have health coverage or make a payment on their federal income tax return called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain other categories of exemptions when you file your federal income tax return.

Who can use this application?

- **Use this application if you and/or anyone in your tax household is a member of an approved religious sect or division whose members are conscientiously opposed to acceptance of the benefits of any private or public insurance, including Medicare and Social Security.**
- If you get this exemption, you can keep it for future years without submitting another application unless you turn 21 or leave your religious sect.
- You may use a single application to ask for this exemption for more than one person in your tax household.

What you may need to apply

- The name and address of your religious sect
- Social Security numbers, if you have them
- If you have one, a copy of an approved IRS Form 4029 ("Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits")

Why do we ask for this information?

We ask for Social Security numbers and other information to make sure your exemption is counted when you file your federal income tax return. **We'll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov or see instructions.

What happens next?

Send your complete, signed application to the address on page 3. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete the exemption process. If you don't hear from us, visit HealthCare.gov, or call **1-800-318-2596**. TTY users should call **1-855-889-4325**.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call our Health Insurance Marketplace Call Center at **1-800-318-2596.**
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596.**

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 1 Tell us about yourself.

(We need one adult in the tax household to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix
[NAME GOES HERE]	[NAME GOES HERE]	[NAME GOES HERE]	

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
[ADDRESS GOES HERE]	[APARTMENT NUMBER GOES HERE]

4. City	5. State	6. ZIP code	7. County
[CITY GOES HERE]			[COUNTY GOES HERE]

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your tax household.

Who do you need to include on this application?

Tell us about each person in the tax household who needs an exemption (don't include dependents who aren't asking for this exemption for themselves). If you get this exemption, we'll give you an Exemption Certificate Number that you'll put on your federal income tax return.

Complete Step 2 for each person in your tax household, except for dependents who aren't asking for this exemption for themselves.

Start with yourself, then add all other adults (whether or not they're requesting this exemption) and any dependents, if you want this exemption for them. Make additional copies of page 2 and attach them for each additional person. You don't need to give a Social Security number (SSN) for members of your tax household who don't need this exemption. Someone asking for an exemption may still be eligible for one even if they don't have an SSN. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for an exemption.

STEP 2

If you have more than one person to include, make a copy of this page and complete.

Complete Step 2 for yourself and/or anyone on your same federal income tax return. Don't fill this out for any dependents who aren't asking for this exemption for themselves.

1. First name | Middle name | Last name | Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

Providing your SSN can be helpful since it can speed up the application process, but you're not required to have an SSN to get this exemption. We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit **socialsecurity.gov**. TTY users should call **1-800-325-0778**.

6. **Tell us about the federal income tax return that you plan to file.**

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return who are requesting this exemption? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Do you need this exemption?

☐ Yes ☐ No. **If no,** leave the rest of this page blank.

8. Do you have an approved IRS Form 4029?

☐ Yes. **If yes,** attach a copy and skip to Step 3. ☐ No

9. Tell us about your religious sect or division.

Name of religious sect or division _____

District or congregation _____

Address: _____

City: _____ State ☐☐ ZIP code ☐☐☐☐☐

10. When did you become a member of this religious sect or division? (mm/yyyy)

☐☐ / ☐☐☐☐

11. If you're not currently a member of this religious sect or division, tell us when you ended your membership. (mm/yyyy)

☐☐ / ☐☐☐☐

9. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

10. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

STEP 3 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell the Health insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit HealthCare.gov or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

What should I do if I think the results of my application are wrong?
If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your exemption application results, log into your Marketplace account at HealthCare.gov/marketplace/individual or call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you've provided the required information listed in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 4 Mail completed application.

Mail your signed application and any copies of approved IRS Form 4029 – "Application for Exemption From Social Security and Medicare Taxes and Waiver of Benefits" (if you told us that you had this) to:

ADDRESS GOES HERE

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

APPENDIX C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

[NAME GOES HERE]

2. Address

[ADDRESS GOES HERE]

3. Apartment or suite number

[APARTMENT NUMBER GOES HERE]

4. City

[CITY GOES HERE]

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name (if applicable)

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

Health Insurance Marketplace

Form Approved
OMB No. 0938-XXXX

Application for Exemption from the Shared Responsibility Payment for Individuals Who Experience Hardships

THINGS TO KNOW

Use this application to apply for an exemption from the shared responsibility payment

- Starting in 2014, every person needs to have health coverage or make a payment on their federal income tax return called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain other categories of exemptions when you file your federal income tax return.

Who can use this application?

- **Use this application if you and/or anyone in your tax household have experienced a hardship that keeps you from getting health coverage. See Table A (after the signature page of this application) for the list of hardships.**
- If you get a hardship exemption, you may qualify for catastrophic coverage.
- You may use one application to ask for this exemption for more than one person in your tax household.

What you may need to apply

- Documents that support your claim of hardship **(see Table A after the signature page of this application)**
- Social Security numbers, if you have them
- Information about people in your tax household

Why do we ask for this information?

We ask for Social Security numbers and other information to make sure your exemption is counted when you file your federal income tax return. **We'll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov.

What happens next?

Send your complete, signed application to the address on page 3. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete the exemption process. If you don't hear from us, visit HealthCare.gov, or call **1-800-318-2596**. TTY users should call **1-855-889-4325**.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call our Health Insurance Marketplace Call Center at **1-800-318-2596.**
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 1 Tell us about yourself.

(We need one adult in the tax household to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix
[NAME GOES HERE]	[NAME GOES HERE]	[NAME GOES HERE]	

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
[ADDRESS GOES HERE]	[APARTMENT NUMBER GOES HERE]

4. City	5. State	6. ZIP code	7. County
[CITY GOES HERE]			[COUNTY GOES HERE]

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your tax household.

Who do you need to include on this application?

Tell us about each person in the tax household who needs an exemption (don't include dependents who aren't asking for this exemption for themselves). If you get this exemption, we'll give you an Exemption Certificate Number that you'll put on your federal income tax return.

Complete Step 2 for each person in your tax household, except for dependents who aren't asking for this exemption for themselves.

Start with yourself, then add all other adults (whether or not they're requesting this exemption) and any dependents, if you want this exemption for them. Make additional copies of page 2 and attach them for each additional person. You don't need to give a Social Security number (SSN) for members of your tax household who don't need this exemption. Someone asking for an exemption may still be eligible for one even if they don't have an SSN. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for an exemption.

STEP 2

If you have more than one person to include, make a copy of this page and complete.

Complete Step 2 for yourself and/or anyone on your same federal income tax return. Don't fill this out for any dependents who aren't asking for this exemption for themselves.

1. First name | Middle name | Last name | Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

Providing your SSN can be helpful since it can speed up the application process, but you're not required to have an SSN to get this exemption. We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit **socialsecurity.gov.** TTY users should call **1-800-325-0778**.

6. **Tell us about the federal income tax return that you plan to file.**

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return who are requesting this exemption? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Do you need this exemption?

☐ **YES** ☐ **NO. If no,** leave the rest of this page blank.

If you have multiple hardships to include, please make a copy of this page for each hardship and answer questions #8–11.

8. Use Table A listed after the signature page to write the number of the hardship you experienced in the box. ☐

9. Unless you're applying for hardship #12 (**Medicaid ineligibility**), please explain how this hardship kept you from getting health insurance for the time period for which you are requesting an exemption:

10. When did this hardship start? (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

11. When did this hardship end? (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

If you're still experiencing this hardship, check: ☐

You must include documentation (described in Table A) to see if you qualify for the exemption.

12. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

13. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov** or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 3 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell the Health insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit **HealthCare.gov** or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

What should I do if I think the results of my application are wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your exemption application results, log into your Marketplace account at **HealthCare.gov/marketplace/individual** or call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you've provided the required information listed in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 4 Mail completed application.

Mail your signed application and the documentation listed in Table A (on the next page) for the exemption you're requesting to:

ADDRESS GOES HERE

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov** or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

TABLE A

Form Approved
OMB No. 0938-1191

Hardship Categories and Documentation

You may qualify for a hardship exemption if you experienced one of the following:

Hardship number (Put this number in box 8 on page 2)	Category	Submit this Documentation with Your Application
1	You were homeless.	None
2	You were evicted in the past 6 months or were facing eviction or foreclosure.	Copy of eviction or foreclosure notice
3	You received a shut-off notice from a utility company.	Copy of shut-off notice from a utility company
4	You recently experienced domestic violence.	None
5	You recently experienced the death of a close family member.	Copy of death certificate, copy of death notice from newspaper, or copy of other official notice of death
6	You experienced a fire, flood, or other natural human-caused disaster that caused substantial damage to your property.	Copy of police or fire report, insurance claim, or other document from government agency or private entity documenting event
7	You filed for bankruptcy in the last 6 months.	Copy of bankruptcy filing
8	You had medical expenses you couldn't pay in the last 24 months.	Copies of medical bills
9	You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.	Copies of receipts related to care
10	You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child.	Copy of medical support order AND copies of eligibility notices for Medicaid and CHIP showing that the child has been denied coverage
11	As a result of an eligibility appeals decision, you're eligible either for: 1) enrollment in a qualified health plan (QHP) through the Marketplace; 2) lower costs on your monthly premiums; or 3) cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace.	Copy of notice of appeals decision
12	You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.	Copy of notice of denial of eligibility for Medicaid

APPENDIX C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

[NAME GOES HERE]

2. Address

[ADDRESS GOES HERE]

3. Apartment or suite number

[APARTMENT NUMBER GOES HERE]

4. City

[CITY GOES HERE]

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

Health Insurance Marketplace

Form Approved
OMB No. 0938-XXXX

Application for Exemption from the Shared Responsibility Payment for Individuals who are Incarcerated (Detained or Jailed)

THINGS TO KNOW

Use this application to apply for an exemption from the shared responsibility payment

- Starting in 2014, every person needs to have health coverage or make a payment on their federal income tax return called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain other categories of exemptions when you file your federal income tax return.

Who can use this application?

- **Use this application if you and/or anyone in your tax household was incarcerated (detained or jailed), other than being held pending disposition of charges.**
- You can also ask the Internal Revenue Service (IRS) for this exemption when you file your federal income tax return.
- Use this application only if you're requesting an exemption for months of incarceration in 2014. If you want to request this exemption for 2014 after the end of 2014, you'll need to claim it on your federal income tax return.

What you may need to apply

- The name and address of the facility where you were incarcerated, and the time periods when you were incarcerated
- Social Security numbers, if you have them
- Information about people in your tax household

Why do we ask for this information?

We ask for Social Security numbers and other information to make sure your exemption is counted when you file your tax return. **We'll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov.

What happens next?

Send your complete, signed application to the address on page 3. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete the exemption process. If you don't hear from us, visit HealthCare.gov, or call **1-800-318-2596**. TTY users should call **1-855-889-4325**.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call our Health Insurance Marketplace Call Center at **1-800-318-2596.**
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 1 Tell us about yourself.

(We need one adult in the tax household to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix
[NAME GOES HERE]	[NAME GOES HERE]	[NAME GOES HERE]	

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
[ADDRESS GOES HERE]	[APARTMENT GOES HERE]

4. City	5. State	6. ZIP code	7. County
[CITY GOES HERE]			[COUNTY GOES HERE]

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your tax household.

Who do you need to include on this application?

Tell us about each person in the tax household who needs an exemption (don't include dependents who aren't asking for this exemption for themselves). If you get this exemption, we'll give you an Exemption Certificate Number that you'll put on your federal income tax return.

Complete Step 2 for each person in your tax household, except for dependents who aren't asking for this exemption for themselves.

Start with yourself, then add all other adults (whether or not they're requesting this exemption) and any dependents, if you want this exemption for them. Make additional copies of page 2 and attach them for each additional person. You don't need to give a Social Security number (SSN) for members of your tax household who don't need this exemption. Someone asking for an exemption may still be eligible for one even if they don't have an SSN. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for an exemption.

STEP 2

If you have more than one person to include, make a copy of this page and complete.

Complete Step 2 for yourself and/or anyone on your same federal income tax return. Don't fill this out for any dependents who aren't asking for this exemption for themselves.

1. First name | Middle name | Last name | Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

Providing your SSN can be helpful since it can speed up the application process, but you're not required to have an SSN to get this exemption. We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit **socialsecurity.gov**. TTY users should call **1-800-325-0778**.

6. **Tell us about the federal income tax return that you plan to file.**

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return who are requesting this exemption? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Do you need this exemption?

☐ **YES.** ☐ **NO. If no,** leave the rest of this page blank.

8. Tell us the entry and release dates for each time period you were incarcerated (detained or jailed) for which you would like an exemption, and where you were incarcerated. Don't include time periods that you were being held pending disposition of charges).

	Entry date (mm/dd/yyyy)	Release date (mm/dd/yyyy)	Name and address of facility
Incarceration period 1	☐☐ / ☐☐ / ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐	
Incarceration period 2	☐☐ / ☐☐ / ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐	
Incarceration period 3	☐☐ / ☐☐ / ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐	

9. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

10. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

STEP 3 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell the Health insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit **HealthCare.gov** or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

What should I do if I think the results of my application are wrong?
If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your tax household.

To appeal your exemption application results, log into your Marketplace account at **HealthCare.gov/marketplace/individual** or call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you've provided the required information listed in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 4 Mail completed application.

Mail your signed application to:

ADDRESS GOES HERE

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

APPENDIX C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

[NAME GOES HERE]

2. Address

[ADDRESS GOES HERE]

3. Apartment or suite number

[APARTMENT GOES HERE]

4. City

[CITY GOES HERE]

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

Form Approved
OMB No. 0938-XXXX

Application for Exemption from the Shared Responsibility Payment for Individuals Who Are Unable to Afford Coverage and Are in a State with a Federally Facilitated Marketplace

THINGS TO KNOW

Use this application to apply for an exemption from the shared responsibility payment

- Starting in 2014, every person needs to have health insurance or make a payment on his or her federal income tax return. This is called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions, and you'll also see some exemption categories when you file your federal income tax return.

Who can use this application?

- **Use this application if you're unable to afford coverage. If you get this exemption, you may be able to buy catastrophic coverage.**
- You don't need to ask for an exemption if you're not going to file a federal income tax return because your income is below the filing threshold.
- Use this application to ask for an exemption for months in the future. If you want this exemption for a whole calendar year, you need to request it before the year starts. You can also claim an exemption on your federal income tax return if you're unable to afford coverage.

What you may need to apply

- Social Security numbers (or document numbers for any legal immigrants asking for an exemption)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know whether you qualify for an exemption. **We'll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov.

What happens next?

Send your complete, signed application to the address on page 8. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete the exemption process. If you don't hear from us, visit HealthCare.gov, or call **1-800-318-2596**. TTY users should call 1-855-889-4325.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call our Health Insurance Marketplace Call Center at **1-800-318-2596**.
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 1 Tell us about yourself.

(We need one adult in the tax household to be the contact person for your application.)

Are you in Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, Wisconsin, or Wyoming?

☐ **YES.** Fill out this application.

☐ **NO.** Visit HealthCare.gov, or call 1-800-318-2596 to find out how to apply for this exemption.

1. First name	Middle name	Last name	Suffix
[NAME GOES HERE]	[NAME GOES HERE]	[NAME GOES HERE]	

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
[ADDRESS GOES HERE]	[APARTMENT NUMBER GOES HERE]

4. City	5. State	6. ZIP code	7. County
[CITY GOES HERE]			[COUNTY GOES HERE]

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your federal income tax return. (If you get this exemption, you'll need to file taxes to use it).

DO Include:

- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you put on your tax return, even if they don't live with you
- Anyone else under 21 you take care of and who lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

This information helps us make sure everyone gets the exemption that they qualify for.

Complete Step 2 for each person in your family.

Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make copies of pages 5–7 and attach them. You don't need to provide immigration status or a Social Security number (SSN) for family members who don't need an exemption. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for an exemption.

STEP 2: PERSON 1

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name	Middle name	Last name	Suffix

2. Relationship to you?	3. Date of birth (mm/dd/yyyy)	4. Sex
SELF	☐☐ / ☐☐ / ☐☐☐☐	☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

Providing your Social Security number (SSN) can be helpful even if you don't want an exemption because it can speed up the application process. We use SSNs to check income and other information to see who is eligible for an exemption, and to help make sure that if you get an exemption, it's applied correctly on your taxes. If you need help getting an SSN, visit socialsecurity.gov, or call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

6. Tell us about the federal income tax return that you plan to file NEXT YEAR.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Do you need this exemption? ☐ Yes. ☐ No. **If no,** leave the rest of the page blank.

8. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

9. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

STEP 2: PERSON 1 (Continue with yourself)

Current job & income information

☐ **Employed:** If you're currently employed, tell us about your income. Start with question 10.

☐ **Not employed:** Skip to question 20.

☐ **Self-employed:** Skip to question 19.

CURRENT JOB 1:

10. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 11. Employer phone number ( ) –

12. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

13. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

14. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 15. Employer phone number ( ) –

16. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

17. Average hours worked each WEEK

18. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

19. **If self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? *(See instructions.)* $

20. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none. ☐

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____
☐ Pension $ How often? _____
☐ Social Security $ How often? _____
☐ Retirement accounts $ How often? _____
☐ Alimony received $ How often? _____
☐ Net farming/fishing $ How often? _____
☐ Net rental/royalty $ How often? _____
☐ Other income Type: _____ $ How often? _____

21. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ How often? _____
☐ Student loan interest $ How often? _____
☐ Other deductions Type: _____ $ How often? _____

22. **YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.**

Your total income **this year** $

Your total income **next** year (if you think it will be different) $

23. If your employer withholds some of your wages and use them to pay for health insurance, list the amount that is withheld each year: $

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 2: PERSON 1 (Continue with yourself)

24. **Are you offered health coverage from a job?**
Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes**, you'll need to complete and include Appendix A, and then skip to Step 3. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, answer all the questions below for other health coverage.**

OTHER HEALTH COVERAGE:

25. **Are you enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage. ☐ **NO.**

- ☐ Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ TRICARE (Don't check if you have direct care or Line of Duty)
- ☐ VA health care programs
- ☐ Peace Corps
- ☐ Employer insurance
  Is this COBRA coverage? ☐ Yes ☐ No
  Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  Is this a limited-benefit plan (like a school accident policy)?
  ☐ Yes ☐ No

26. Are you pregnant? ☐ Yes. ☐ No. a. **If yes**, how many babies are expected during this pregnancy? ☐

27. Do you live with at least one child under 19, and are you the main person taking care of this child? ☐ Yes ☐ No

28. Are you a full-time student? ☐ Yes ☐ No

29. Were you in foster care at age 18 or older? ☐ Yes ☐ No

30. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

31. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? *(See instructions.)*

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Have you lived in the U.S. since 1996?
☐ Yes ☐ No

d. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

THANKS! This is all we need to know about you.

STEP 2: PERSON 2

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 5, 6 and 7) and complete.

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

Providing PERSON 2's Social Security number (SSN) can be helpful even if PERSON 2 doesn't want an exemption because it can speed up the application process. We use SSNs to check income and other information to see who is eligible for an exemption, and to help make sure that if PERSON 2 gets an exemption, it's applied correctly on their taxes. If PERSON 2 needs help getting an SSN, visit socialsecurity.gov, or call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

6. Tell us about the federal income tax return that PERSON 2 plans to file NEXT YEAR.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Does PERSON 2 need this exemption?

☐ Yes. ☐ No. **If no,** leave the rest of the page blank.

8. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

9. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

STEP 2: PERSON 2

Current job & income information

☐ **Employed:** If PERSON 2 is currently employed, tell us about his or her income. Start with question 10.

☐ **Not employed:** Skip to question 20.

☐ **Self-employed:** Skip to question 19.

CURRENT JOB 1:

10. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 11. Employer phone number ( ) –

12. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

13. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 2 has more jobs, attach another sheet of paper.)

14. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 15. Employer phone number ( ) –

16. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

17. Average hours worked each WEEK

18. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

19. **If PERSON 2 is self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month? *(See instructions.)* $

210. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. Check here if none. ☐

NOTE: You don't need to tell us about PERSON 2's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____
☐ Pension $ How often? _____
☐ Social Security $ How often? _____
☐ Retirement accounts $ How often? _____
☐ Alimony received $ How often? _____
☐ Net farming/fishing $ How often? _____
☐ Net rental/royalty $ How often? _____
☐ Other income Type: _____ $ How often? _____

21. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it. If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ How often? _____
☐ Student loan interest $ How often? _____
☐ Other deductions Type: _____ $ How often? _____

22. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month. If you don't expect changes to PERSON 2's monthly income, skip to the next person.**

PERSON 2's total income **this year** $

PERSON 2's total income **next** year (if you think it will be different) $

23. If PERSON's employer withholds some of their wages and use them to pay for health insurance, list the amount that is withheld each year: $

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 2: PERSON 2

24. **Is PERSON 2 offered health coverage from a job?**
Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes**, you'll need to complete and include Appendix A, and then skip to Step 3. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, answer all the questions below for other health coverage.**

OTHER HEALTH COVERAGE:

25. **Is PERSON 2 enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage. ☐ **NO.**

- ☐ Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ TRICARE (Don't check if you have direct care or Line of Duty)
- ☐ VA health care programs
- ☐ Peace Corps
- ☐ Employer insurance
  Is this COBRA coverage? ☐ Yes ☐ No
  Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  Is this a limited-benefit plan (like a school accident policy)?
  ☐ Yes ☐ No

26. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes**, how many babies are expected during this pregnancy? ☐

27. Does PERSON 2 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? ☐ Yes ☐ No

28. Is PERSON 2 a full-time student? ☐ Yes ☐ No

29. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

30. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

31. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? *(See instructions.)*

☐ Yes. Fill in PERSON 2's document type and ID number below.

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Has PERSON 2 lived in the U.S. since 1996?
☐ Yes ☐ No

d. Is PERSON 2, or PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

THANKS! This is all we need to know about PERSON 2.

STEP 3 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've given true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I give false and/or untrue information.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

We need this information to check your eligibility for an exemption if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

What should I do if I think the results of my application are wrong?
If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your exemption application results, log into your Marketplace account at HealthCare.gov/marketplace/individual or call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the required information listed in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 4 Mail completed application.

Mail your signed application to:

ADDRESS GOES HERE

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

APPENDIX A: EXEMPTIONS

Form Approved
OMB No. 0938-1191

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.
Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

Employee information

1. Employee name (First, Middle, Last)	2. Employee Social Security number
	☐☐☐ - ☐☐ - ☐☐☐☐

Employer information

3. Employer name	4. Employer Identification Number (EIN)
	☐☐ - ☐☐☐☐☐☐☐
5. Employer address	6. Employer phone number
	(☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State / 9. ZIP code
	☐☐ / ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address
(☐☐☐) ☐☐☐ – ☐☐☐☐	

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. **If you're in a waiting or probationary period, when can you enroll in coverage?** (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15a. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

15b. For the lowest-cost plan that meets the minimum value standard* offered **to the employee and family members requesting an exemption** (only include family plans for family members that do not already have an exemption): If the employer has wellness programs, provide the premium that the employee would pay if they don't get a discount for wellness programs, including smoking cessation programs.

a. How much would the employee have to pay in premiums for this plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

EMPLOYER COVERAGE TOOL: EXEMPTIONS

Health Insurance Marketplace
Form Approved
OMB No. 0938-1191

Use this tool to help answer questions in your Marketplace application, Appendix A. That part of the application asks about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or a spouse). The information in the numbered boxes below match the boxes in Appendix A. For example, you can use the answer to question 14 on this page to answer question 14 on Appendix A.
Write your name and Social Security number in boxes 1 and 2 and ask the employee to fill out the rest of the form. Complete one tool for each employer that offers health coverage that you're eligible for.

EMPLOYEE information
The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
	☐☐☐ - ☐☐ - ☐☐☐☐

EMPLOYER information
Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN)
	☐☐ - ☐☐☐☐☐☐☐
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number
	(☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State / 9. ZIP code
	☐☐ / ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above) (☐☐☐) ☐☐☐ – ☐☐☐☐	12. Email address

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**
- ☐ **Yes** (Go to question 13a.)
  - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Go to next question)
- ☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?
- ☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)
- ☐ No (Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?
- ☐ Yes (Go to question 15) ☐ No (STOP and return this form to employee)

15a. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
- a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐
- b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

15b. For the lowest-cost plan that meets the minimum value standard* offered **to the employee and family members requesting an exemption** (only include family plans for family members that do not already have an exemption): If the employer has wellness programs, provide the premium that the employee would pay if they don't get a discount for wellness programs, including smoking cessation programs.
- a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐
- b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return this form to employee.

16. What change will the employer make for the new plan year?
- ☐ Employer won't offer health coverage
- ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)
  - a. How much will the employee have to pay in premiums for that plan? $ ☐☐☐☐☐☐
  - b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly
  - c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

APPENDIX C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

[NAME GOES HERE]

2. Address

[ADDRESS GOES HERE]

3. Apartment or suite number

[APARTMENT GOES HERE]

4. City

[CITY GOES HERE]

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

Form Approved
OMB No. 0938-XXXX

Application for Exemption from the Shared Responsibility Payment for Individuals Who Are Unable to Afford Coverage and Are in Certain States with a State Based Marketplace

THINGS TO KNOW

Use this application to apply for an exemption from the shared responsibility payment

- Starting in 2014, every person needs to have health insurance or make a payment on their federal income tax return called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes some categories of exemptions, and you'll see other categories when you file your federal income tax return.

Who can use this application?

- **Use this application if your state has its own Marketplace. Visit HealthCare.gov, or call 1-800-318-2596 to see if your state has its own Marketplace. TTY users should call 1-855-889-4325.**
- **Use this application if you're unable to afford coverage. If you get this exemption, you may be able to buy catastrophic coverage.**
- You don't need to ask for an exemption if you're not going to file a federal income tax return because your income is below the filing threshold.
- Use this application to ask for an exemption for months in the future. If you want this exemption for a whole calendar year, you need to request it before the year starts. You can also claim an exemption on your federal income tax return if you're unable to afford coverage.

What you may need to apply

- Social Security numbers (or document numbers for any legal immigrants who are seeking an exemption)
- Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance information about any job-related health insurance available to your family
- Information on premium for the lowest cost Bronze Plan that your state offers, after applying any tax credits you can get

Why do we ask for this information?

We ask about income and other information to let you know whether you qualify for an exemption. **We'll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov.

What happens next?

Send your complete, signed application to the address on page 5. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete the exemption process. If you don't hear from us, visit HealthCare.gov, or call **1-800-318-2596**. TTY users should call 1-855-889-4325.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call our Health Insurance Marketplace Call Center at **1-800-318-2596**.
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 1 Tell us about yourself.

(We need one adult in the tax household to be the contact person for your application.)

Are you in [list of SBM states that are having HHS handle exemptions]?

☐ **YES.** Fill out this application.

☐ **NO.** Visit HealthCare.gov, or call 1-800-318-2596 to find out how to apply for this exemption.

1. First name	Middle name	Last name	Suffix
[NAME GOES HERE]	[NAME GOES HERE]	[NAME GOES HERE]	

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
[ADDRESS GOES HERE]	[APARTMENT NUMBER GOES HERE]

4. City	5. State	6. ZIP code	7. County
[CITY GOES HERE]			[COUNTY GOES HERE]

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about everyone on your federal income tax return, even if they don't need this exemption. (If you get this exemption, you'll need to file taxes to use it).

Complete Step 2 for each person in your family.

Start with yourself, then add other adults and children (whether or not they're requesting an exemption). If you have more than 2 people in your family, you'll need to make copies of page 2 and attach them. You don't need to provide immigration status or a Social Security number (SSN) for family members who don't need an exemption. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for an exemption.

STEP 2: PERSON 1

Complete Step 2 for yourself and anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you won't file a tax return because you'll have income below the filing threshold, you don't need to request this exemption.

1. First name | Middle name | Last name | Suffix

2. Relationship to you?
SELF

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

Providing your Social Security number (SSN) can be helpful even if you don't want an exemption because it can speed up the application process. We use SSNs to check income and other information to see who is eligible for an exemption, and to help make sure that if you get an exemption, it's applied correctly on your taxes. If you need help getting an SSN, visit **socialsecurity.gov**, or call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

6. Tell us about the federal income tax return that you plan to file NEXT YEAR.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Do you need this exemption? ☐ Yes. ☐ No. **If no,** leave the rest of the page blank.

8. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

9. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

10. **YEARLY INCOME:** Include wages/tips (before taxes), net income from self-employment, unemployment benefits, pensions, Social Security (except Supplemental Security Income and old age, survivor's or disability payments that aren't taxable), retirement accounts, alimony received, net farming and fishing income, net rental and royalty income, and anything else that you would include on your taxes. You don't need to tell us about child support or veterans' payments

Your total income **this year** $ ☐☐☐☐☐☐

Your total income **next year** (if you think it will be different) $ ☐☐☐☐☐☐

11. If your employer withholds some of your wages and uses them to pay for health insurance, list the amount that is withheld each year
$ ☐☐☐☐☐☐

12. Are you offered health coverage from a job? Check "yes" even if the coverage is from someone else's job, such as a parent or spouse.
☐ **YES. If yes**, you'll need to complete and include Appendix A.
☐ **NO.** If no, skip to Step 3.

THANKS! This is all we need to know about you.

STEP 2: PERSON 2

If you have more than two people to include, make a copy of Step 2: Person 2 and complete.

Complete Step 2 for yourself and anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you won't file a tax return because you'll have income below the filing threshold, you don't need to request this exemption.

1. First name	Middle name	Last name	Suffix

2. Relationship to you?	3. Date of birth (mm/dd/yyyy)	4. Sex
	☐☐ / ☐☐ / ☐☐☐☐	☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

Providing your Social Security number (SSN) can be helpful even if you don't want an exemption because it can speed up the application process. We use SSNs to check income and other information to see who is eligible for an exemption, and to help make sure that if you get an exemption, it's applied correctly on your taxes. If you need help getting an SSN, visit **socialsecurity.gov**, or call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

6. Tell us about the federal income tax return that PERSON 2 plans to file NEXT YEAR.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Does PERSON 2 need this exemption? ☐ Yes ☐ No **If no,** leave the rest of the page blank.

8. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

9. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

10. **YEARLY INCOME:** Include wages/tips (before taxes), net income from self-employment, unemployment benefits, pensions, Social Security (except Supplemental Security Income and old age, survivor's or disability payments that aren't taxable), retirement accounts, alimony received, net farming and fishing income, net rental and royalty income, and anything else that PERSON 2 would include on your taxes. You don't need to tell us about child support or veterans' payments.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$ ☐☐☐☐☐☐	$ ☐☐☐☐☐☐

11. If PERSON 2's employer withholds some of PERSON 2's wages and uses them to pay for health insurance, list the amount that is withheld each year

$ ☐☐☐☐☐☐

12. Is PERSON 2 offered health coverage from a job? Check "yes" even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes**, you'll need to complete and include Appendix A.

☐ **NO.** If no, skip to Step 3.

THANKS! This is all we need to know about PERSON 2.

STEP 3 Lowest Cost Marketplace Plan

- For anyone who is applying for this exemption who isn't offered health coverage through a job, including a spouse or parent's job, your ability to get this exemption is based on the cost of the lowest-cost bronze plan that is available through your state's Marketplace, after applying any tax credits you can get.
- This information is only available through your state's Marketplace.
- So, if anyone answered "No" to question 12 above—meaning that they aren't offered health coverage through a job—we need you to submit an application for health insurance to your state's Marketplace, complete the process, and send us two things:
  1. A copy of the eligibility notice from your state's Marketplace that shows your maximum premium tax credit.
  2. A copy of the screen from your Marketplace's plan comparison tool that shows the premium of the lowest-cost bronze plan available to everyone who is requesting this exemption. If there isn't a single bronze plan that covers everyone in your tax household who is requesting an exemption, send us the screens showing the lowest-cost bronze plans that add together to have the lowest cost for everyone.

If you need help locating this information, you can call your state's Marketplace. The phone numbers are listed below:

[INSERT LIST OF STATE-BASED MARKETPLACE PHONE NUMBERS]

STEP 4 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've given true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I give false and or untrue information.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

We need this information to check your eligibility for an exemption if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS) and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

What should I do if I think the results of my application are wrong?
If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your exemption application results, log into your Marketplace account at **HealthCare.gov/marketplace/individual** or call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the required information listed in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 5 Mail completed application.

Mail your signed application to:

ADDRESS GOES HERE

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov** or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

APPENDIX A: EXEMPTIONS

Form Approved
OMB No. 0938-1191

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.
Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

Employee information

1. Employee name (First, Middle, Last)	2. Employee Social Security number
	☐☐☐ - ☐☐ - ☐☐☐☐

Employer information

3. Employer name	4. Employer Identification Number (EIN)
	☐☐ - ☐☐☐☐☐☐☐
5. Employer address	6. Employer phone number
	(☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State / 9. ZIP code
	☐☐ / ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address
(☐☐☐) ☐☐☐ – ☐☐☐☐	

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. **If you're in a waiting or probationary period, when can you enroll in coverage?** (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15a. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

15b. For the lowest-cost plan that meets the minimum value standard* offered **to the employee and family members requesting an exemption** (only include family plans for family members that do not already have an exemption): If the employer has wellness programs, provide the premium that the employee would pay if they don't get a discount for wellness programs, including smoking cessation programs.

a. How much would the employee have to pay in premiums for this plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

EMPLOYER COVERAGE TOOL: EXEMPTIONS

Health Insurance Marketplace
Form Approved
OMB No. 0938-1191

Use this tool to help answer questions in your Marketplace application, Appendix A. That part of the application asks about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or a spouse). The information in the numbered boxes below match the boxes in Appendix A. For example, you can use the answer to question 14 on this page to answer question 14 on Appendix A.
Write your name and Social Security number in boxes 1 and 2 and ask the employee to fill out the rest of the form. Complete one tool for each employer that offers health coverage that you're eligible for.

EMPLOYEE information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
	☐☐☐ - ☐☐ - ☐☐☐☐

EMPLOYER information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN)
	☐☐ - ☐☐☐☐☐☐☐
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number
	(☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State / 9. ZIP code
	☐☐ / ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address
(☐☐☐) ☐☐☐ – ☐☐☐☐	

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**
- ☐ **Yes** (Go to question 13a.)
  - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Go to next question)
- ☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?
- ☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)
- ☐ No (Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?
- ☐ Yes (Go to question 15) ☐ No (STOP and return this form to employee)

15a. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
- a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐
- b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

15b. For the lowest-cost plan that meets the minimum value standard* offered **to the employee and family members requesting an exemption** (only include family plans for family members that do not already have an exemption): If the employer has wellness programs, provide the premium that the employee would pay if they don't get a discount for wellness programs, including smoking cessation programs.
- a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐
- b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return this form to employee.

16. What change will the employer make for the new plan year?
- ☐ Employer won't offer health coverage
- ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)
  - a. How much will the employee have to pay in premiums for that plan? $ ☐☐☐☐☐☐
  - b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly
  - c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

APPENDIX C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

[NAME GOES HERE]

2. Address

[ADDRESS GOES HERE]

3. Apartment or suite number

[APARTMENT GOES HERE]

4. City

[CITY GOES HERE]

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

Health Insurance Marketplace

Form Approved
OMB No. 0938-XXXX

Application for Exemption from the Shared Responsibility Payment for Members of a Health Care Sharing Ministry

THINGS TO KNOW

Use this application to apply for an exemption from the shared responsibility payment

- Starting in 2014, every person needs to have health coverage or make a payment on their federal income tax return called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain other categories of exemptions when you file your federal income tax return.

Who can use this application?

- **Use this application if you and/or anyone in your tax household is/was a member of a health care sharing ministry that is recognized by the Health Insurance Marketplace. A health care sharing ministry is an organization whose members share a common set of ethical and religious beliefs and share medical expenses among themselves in accordance with these beliefs.**
- You can also ask the Internal Revenue Service (IRS) for this exemption when you file your federal income tax return.
- Use this application only if you're requesting an exemption for months of membership in a health care sharing ministry for 2014. If you want to request this exemption for 2014 after the end of 2014, you'll need to claim it on your federal income tax return.

What you may need to apply

- The name and address of the health care sharing ministry of which you are a member
- Social Security numbers, if you have them
- Information about people in your tax household

Why do we ask for this information?

We ask for Social Security numbers and other information to make sure your exemption is counted when you file your federal income tax return. **We'll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov.

What happens next?

Send your complete, signed application to the address on page 3. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete the exemption process. If you don't hear from us, visit HealthCare.gov, or call **1-800-318-2596**. TTY users should call **1-855-889-4325**.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call our Health Insurance Marketplace Call Center at **1-800-318-2596.**
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 1 Tell us about yourself.

(We need one adult in the tax household to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix
[NAME GOES HERE]	[NAME GOES HERE]	[NAME GOES HERE]	

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
[ADDRESS GOES HERE]	

4. City	5. State	6. ZIP code	7. County
[CITY GOES HERE]			[COUNTY GOES HERE]

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your tax household.

Who do you need to include on this application?

Tell us about each person in the tax household who needs an exemption (don't include dependents who aren't asking for this exemption for themselves). If you get this exemption, we'll give you an Exemption Certificate Number that you'll put on your federal income tax return.

Complete Step 2 for each person in your tax household, except for dependents who aren't asking for this exemption for themselves.

Start with yourself, then add all other adults (whether or not they're requesting this exemption) and any dependents, if you want this exemption for them. Make additional copies of page 2 and attach them for each additional person. You don't need to give a Social Security number (SSN) for members of your tax household who don't need this exemption. Someone asking for an exemption may still be eligible for one even if they don't have an SSN. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for an exemption.

STEP 2

If you have more than one person to include, make a copy of this page and complete.

Complete Step 2 for yourself and/or anyone on your same federal income tax return. Don't fill this out for any dependents who aren't asking for this exemption for themselves.

1. First name | Middle name | Last name | Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

Providing your SSN can be helpful since it can speed up the application process, but you're not required to have an SSN to get this exemption. We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit socialsecurity.gov. TTY users should call **1-800-325-0778**.

6. **Tell us about the federal income tax return that you plan to file.**

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return who are requesting this exemption? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Do you need this exemption?

☐ **YES** ☐ **NO. If no,** leave the rest of this page blank.

8. Tell us about the Health Care Sharing Ministry you're a member of.

Name of Health Care Sharing Ministry: _____

Address: _____

City: _____ State ☐☐ ZIP code ☐☐☐☐☐

9. Tell us about time periods when you were a member in good standing—that is, periods when you met all membership requirements, including making any financial contributions required to remain a member.

Date range 1 (mm/yyyy – mm/yyyy): ☐☐ / ☐☐☐☐ – ☐☐ / ☐☐☐☐

Date range 2 (mm/yyyy – mm/yyyy): ☐☐ / ☐☐☐☐ – ☐☐ / ☐☐☐☐

Date range 3 (mm/yyyy – mm/yyyy): ☐☐ / ☐☐☐☐ – ☐☐ / ☐☐☐☐

10. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

11. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

STEP 3 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell the Health insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit **HealthCare.gov** or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

What should I do if I think the results of my application are wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your exemption application results, log into your Marketplace account at **HealthCare.gov/marketplace/individual** or call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you've provided the required information listed in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 4 Mail completed application.

Mail your signed application to:

ADDRESS GOES HERE

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov** or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

APPENDIX C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

[NAME GOES HERE]

2. Address

[ADDRESS GOES HERE]

3. Apartment or suite number

[APARTMENT NUMBER GOES HERE]

4. City

[CITY GOES HERE]

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

Health Insurance Marketplace

Form Approved
OMB No. 0938-XXXX

Application for Exemption from the Shared Responsibility Payment for Members of Federally Recognized Tribes and Other Individuals Who are Eligible to Receive Services from an Indian Health Care Provider

THINGS TO KNOW

Use this application to apply for an exemption from the shared responsibility payment

- Starting in 2014, every person needs to have health coverage or make a payment on their federal tax return called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain other categories of exemptions when you file your federal income tax return. If you're a member of a federally recognized tribe, you can also ask the Internal Revenue Service (IRS) for this exemption when you file your federal income tax return.

Who can use this application?

- **Use this application if you and/or anyone in your tax household is:**
  - **A member of a federally recognized tribe**
  - **Another individual who is eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations**
- If you get this exemption, you can keep it for future years without submitting another application if your membership or eligibility for services from an Indian health care provider remains unchanged.

What you may need to apply

- Documentation showing tribal membership or eligibility for services from the Indian Health Service, a tribal health care provider, or an urban Indian health care provider
- Social Security numbers, if you have them
- Information about people in your tax household

Why do we ask for this information?

We ask for Social Security numbers and other information to make sure your exemption is counted when you file your tax return. **We'll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov.

What happens next?

Send your complete, signed application to the address on page 3. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete the exemption process. If you don't hear from us, visit HealthCare.gov, or call **1-800-318-2596**. TTY users should call **1-855-889-4325**.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call our Health Insurance Marketplace Call Center at **1-800-318-2596**.
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 1 Tell us about yourself.

(We need one adult in the tax household to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix
[NAME GOES HERE]	[NAME GOES HERE]	[NAME GOES HERE]	

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
[ADDRESS GOES HERE]	[APARTMENT GOES HERE]

4. City	5. State	6. ZIP code	7. County
[CITY GOES HERE]			[COUNTY GOES HERE]

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your tax household.

Who do you need to include on this application?

Tell us about each person in the tax household who needs an exemption (don't include dependents who aren't asking for this exemption for themselves). If you get this exemption, we'll give you an Exemption Certificate Number that you will put on your federal income tax return.

Complete Step 2 for each person in your tax household, except for dependents who aren't asking for this exemption for themselves.

Start with yourself, then add all other adults (whether or not they're requesting this exemption) and any dependents, if you want this exemption for them. Make additional copies of page 3 and attach them for each additional person. You don't need to give a Social Security number (SSN) for members of your tax household who don't need this exemption. Someone asking for an exemption may still be eligible for one even if they don't have an SSN. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for an exemption.

STEP 2

If you have more than one person to include, make a copy of this page and complete.

Complete Step 2 for yourself and/or anyone on your same federal income tax return. Don't fill this out for any dependents who aren't asking for this exemption for themselves.

1. First name | Middle name | Last name | Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

Providing your SSN can be helpful since it can speed up the application process, but you're not required to have an SSN to get this exemption. We use SSNs to help make sure that if you get an exemption, it is applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit **socialsecurity.gov**. TTY users should call **1-800-325-0778**.

6. **Tell us about the federal income tax return that you plan to file.**

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return who are requesting this exemption? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Do you need this exemption?

☐ **YES.** ☐ **NO.** **If no,** leave the rest of the page blank.

8. Are you a member of a federally recognized tribe?

☐ Yes. If yes, skip to question 10. ☐ No

9. Are you eligible to get services through an Indian health care provider **only** because you are pregnant with the child of a member of a federally recognized tribe?

☐ **YES.** If yes, when is your baby (or babies) due (mm/yyyy)?

☐☐ / ☐☐☐☐ then skip to Question 13

☐ **NO.** If no, skip to the next question.

10. Are you eligible to get services through an Indian health care provider?

☐ **YES.** If yes, answer questions 11 and 12. ☐ **NO.** If no, then skip to Question 13.

11. If you have not always been eligible for services through an Indian health care provider (i.e., spouse of a member of a federally recognized tribe who would not otherwise be eligible), when did you become eligible for such services (mm/dd/yyyy)?

☐☐ / ☐☐ / ☐☐☐☐

12. If you know that your eligibilty for services through an Indian health care provider has ended or will end (i.e., due to a divorce or will turn 19 years old and would not otherwise be eligible for such services), please provide the date (mm/dd/yyyy).

☐☐ / ☐☐ / ☐☐☐☐

13. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

14. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

STEP 3 Read & sign this application

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell the Health insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit **HealthCare.gov** or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

What should I do if I think the results of my application are wrong?

If you don't agree with what you qualify for, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your exemption application results, log into your Marketplace account at **HealthCare.gov/marketplace/individual** or call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you've provided the required information listed in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 4 Mail completed application.

Include your documentation showing tribal membership or eligibility for services through the Indian Health Services, a tribal health care provider, or an Urban Indian health care provider and mail your signed application to:

ADDRESS GOES HERE

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

APPENDIX C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

[NAME GOES HERE]

2. Address

[ADDRESS GOES HERE]

3. Apartment or suite number

[APARTMENT NUMBER GOES HERE]

4. City

[CITY GOES HERE]

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.